News At Nine

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TRICARE Southern California

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California TRICARE is Y2K Ready and More

By Lt. Bob Tatum, USN

Many companies are testing their computer systems to ensure continued operation during and after the Y2K rollover, but for the military health care system, continued operation means much more than making sure computer dates will be correct on Jan. 1, 2000.

Healthcare involves far more than just computers and dates. The military health care system includes buildings, equipment, military and civilian providers, and of course, patients. On top of all this, an emergency plan needs to be in place to handle emergencies at any time.

To ensure the entire healthcare system was ready for the year 2000, and not just the computers, all military medical treatment facilities (MTFs) in California participated in a unique medical readiness exercise designed to ensure all mission-essential functions remain functional. The Statewide Joint-Service Disaster Exercise, the first of its kind, was run simultaneously with California's Emergency Medical Service Authority's Y2K hospital disaster exercise, designed to test the limits of the state's health care infrastructure.

Navy Lt. Lorenzo Jones, Medical Service Corps, is the Medical Contingency Planner at TRICARE Region Nine. As the exercise coordinator for all MTFs in California, encompassing both Regions Nine and Ten for TRICARE, he sees the importance for exercises such as this.

"This exercise tested several important features of the military health system. We ensured that all MTFs had tested, repaired or replaced all non-Y2K-compliant medical equipment; we tested each MTF's disaster plan; and we made

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From the Lead Agent

Rear Adm. Alberto Diaz, Jr., MC, USN

CLINICAL CARE AND CUSTOMER SATISFACTION

One of the biggest challenges facing managed care today is how to meet the needs of the patient with the ever-shrinking resources available to the healthcare provider. We've seen the television and newspaper accounts about reduced health benefits, shortened hospital stays and denied claims in the public sector. Sometimes it seems like managed care and quality healthcare are mutually exclusive terms.

Fortunately, there is a solution to this seemingly unsolvable problem, and it is called Population Health. Population Health focuses on keeping healthy people healthy, managing disease treatment to prevent complications, and using data to ensure limited resources are used efficiently and equitably. Population Health initiatives may be as transparent as fluoride in the water, or as interactive as smoking cessation classes, but patient education plays a key role. Educational programs about safe sex, drug abuse and proper nutrition are all designed to keep the patient healthy and out of the doctor's office. Disease management initiatives include teaching asthma and diabetes patients how to monitor and treat their own conditions, giving them greater independence. Better health for patients means fewer visits to the doctor, less medicine to take, and a longer, more active life.

Data collection plays a major role in an effective Population Health program. TRICARE's Population Health Operational Tracking and Oversight (PHOTO) System is a report card combining a patient's overall satisfaction and the clinical indicators of their health. The data for each patient helps maximize the efficiency of each doctor/patient interaction and ensures no area of the patient's healthcare is overlooked. Thanks to new concepts like managed care and Population Health, customer satisfaction is at its highest level ever. Or is it?

The quality of healthcare has come a long way in the last century. We've all seen the old movies where the country doctor travels by horse and buggy to an old farmhouse to visit a sick patient. The only resources he has are his bedside manners and whatever is hidden away in his little black medical bag. In the end, his bedside manners are always more comforting to the patient and family than the limited medical technology of his time.

Fortunately, healthcare providers today are much better equipped than the doctors of old. Technological advances in pharmaceuticals, microsurgery and genetic research have given both doctors and patients options that were only a dream 100 years ago. But like other technologies, modern medicine and the people who use it have not kept pace with each other. With so many miraculous tools at our fingertips, we have often shifted our focus away from the patient and on to the technology. We have forgotten about the medicinal effects of compassion, friendliness and respect. By focusing only on the quality of our clinical care we have often neglected the interpersonal relationships that are so important to our patients' health and satisfaction.

For years we thought the only product we delivered to our patients was proper clinical care. We believed that as long as our patients received good care, their satisfaction would be a natural byproduct. I can tell you, from my vantage point, that patient satisfaction does not happen by itself. If we are to really meet our patients' needs, then we need to think of patient satisfaction as a principal product we deliver, and not just a byproduct.

Traditionally, our approach to patient satisfaction has been reactionary. When a patient complained, we reacted by addressing those complaints, but didn't make much of an effort to change the way we really did business. Most of the patient complaints I receive concern their personal interactions with their healthcare providers or other hospital staff: a rude word, an attitude of indifference, or even a facial expression. These patients aren't complaining about the quality of their clinical care, but about the quality of the other product we deliver: customer satisfaction. How easily these complaints could have been avoided. As we move into the 21st century, one of our goals in Region Nine is for the quality of our customer satisfaction efforts catch up with the quality of our clinical efforts. Only then will our patients receive quality healthcare.

Military's Top Doctor Pledges Better TRICARE Service

By Deborah Funk

Dr. Sue Bailey

Imagine this: You call TRICARE to schedule an appointment and your call is answered swiftly.

Or how about this? TRICARE pays your civilian doctor within 30 days, and you don't have to worry about receiving a collection notice.

Sound like a dream? Well, the military's top doctor says those service improvements are just around the corner as TRICARE begins to mature.

Following last year's significant improvements in pay, retirement and benefits, top Pentagon officials are taking a close look at quality-of-life issues. Chief among them are improvements in TRICARE, the military's 5-year-old health-care program, which includes military and civilian hospitals, clinics and doctors.

"Keep in mind, many of TRICARE's problems are business problems," said Dr. Sue Bailey, assistant defense secretary for health affairs. Because those business problems can make life miserable for military families that need health care, defense officials are directing changes in the way some things are done.

In accordance with recent policy changes, all TRICARE claims must be paid within 60 days, with the overwhelming majority paid in half that time. Ninety-five percent of the claims submitted with all information needed for processing must be paid in 30 days or less. The balance must be paid in 60 days.

In late summer, TRICARE patients will be able to use the same appointment process whether they are calling a military hospital or clinic, or a civilian doctor.

TRICARE Service Centers will be moved onto installations to make them more accessible to military families. Many already are there, but some are located in civilian strip malls and other locations off post.

A new defense health policy requires that the service centers be accessible, whether they are in a military hospital or clinic or somewhere else on the installation.

Overall, TRICARE's vital signs are good, Bailey said.

"I really believe it is healthier than it's ever been," she told Air Force Times in an interview.

Y2K Ready

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sure that the MTFs were ready to provide care to both beneficiaries and to the civilian community," Jones said.

Another important feature of running this exercise was the coordination with California's statewide Y2K hospital disaster exercise. Through an agreement between local communities and the military, civilians may go to a military hospital for immediate emergency treatment, in effect making all military hospitals part of the statewide hospital system. The simultaneous exercises allowed hospitals to coordinate resources such as bed availability during disaster scenarios.

The exercise tested each MTF's disaster plan, checked the back-up generator system, other vital systems such as water supply, and used alternative communications (other than phone lines) to communicate between facilities. The exercise also assessed the ability of Foundation Health Federal Services (the TRICARE civilian network provider in California) to implement contingency plans to effectively reroute phone calls and/or reschedule appointments. The ability of MTFs to respond to a large influx of patients, communications between ambulance personnel and healthcare facilities, and the availability of medical supplies was also assessed.

"This unprecedented statewide exercise revealed that the military healthcare system can work in concert to provide healthcare during unique and difficult circumstances. This exercise ensured that not only is our equipment Y2K ready, but that we have plans in place to respond to a multiple-incident disaster scenario," Jones said.

Congress Considers Healthcare Changes for Guard and Reservists

By Douglas J. Gillert
American Forces Press Service

WASHINGTON — An Air Force Reserve technical sergeant was called to active duty in Kosovo. Before the call-up, he, his wife and their three children got their medical care from a civilian dentist through his employer's medical insurance plan. The plan didn't cover them, however, once he left for active duty.

He walked into his military health care office to enroll his family for dental care. The clerk asked to see his orders, which stated, "You are hereby called to active duty for a period not to exceed 270 days."

"We're sorry," the personnel clerk said. "We can't put your family into the military dental care program, because you need two years of obligated active duty in order to enroll."

Charles Cragin, assistant defense secretary for reserve affairs, related this true story as an example of how reserve component members often don't get the same level of care as their active duty counterparts, even when they perform the same duties.

"Duty status shouldn't determine the level of health care reservists and their families get," he said. Instead, according to a new entitlement study, their care should be based on the reservists' exposure to risk or harm.

The report Defense Secretary William S. Cohen sent to Congress in mid-November recommends sweeping changes to the statutes and policies covering health care benefits and entitlements for Guard and Reserve members. Cragin called the study vitally important because of the number of "disconnects" created by America's increased reliance on the Guard and Reserve to meet worldwide mission requirements.

"There are guardsmen and reservists serving on active duty someplace, somewhere, every day," he said. "They may only serve for two months, but they're serving. So we had to get away from the issue of status determining the level of health care they get."

The study recommends 14 changes to the health entitlements of reservists and their families and force health protection. Several of the recommendations have already been adopted in the fiscal 2000 Defense Authorization Act.

One provision under the act allows DoD to place a reserve component member on active duty while he's treated or is recovering from an injury, illness or disease incurred while performing inactive duty training. More far reaching are the act's provisions expanding dental care to cover reservists' families and giving the defense secretary authority to waive or reduce TRICARE Standard's annual $300 deductible per family when reservists are ordered to active duty for less than one year to support a contingency operation.

Recommendations Congress still must consider include identifying non-DoD resources for accomplishing such readiness requirements as annual physicals and immunizations. These could come from the Department of Veterans Affairs, Public Health Service, civilian contractors and private practitioners, Cragin said. The study also recommends creating a dental exam and classification form that any licensed dentist could complete and that would satisfy the DoD annual dental examination and classification requirement.

"These folks don't serve on active duty 365 days a year," Cragin said. "Therefore, we want to maximize the utility of time we have with them. If we can develop this certification form that they can take to their civilian dentist, for example, we'll save the time of having to go through that on a drill weekend.

"It's the same with physicals. We're looking to expand the universe that can be used to meet the physical, dental and medical assessment requirements for evaluating guardsmen and reservists."

Dental care also will get a boost with the already approved merger of the Reserve Member Dental Program and the TRICARE Family Member Dental Program, which currently covers only active duty families. After the merger, families of reservists will, for the first time, be able to receive dental care at reduced costs.

The recommendations sent to Congress include a proposal for a long-term study to look at the overall medical readiness of reserve forces. The study would help DoD identify potential health risks and ways to better assess reserve component health, Cragin said.

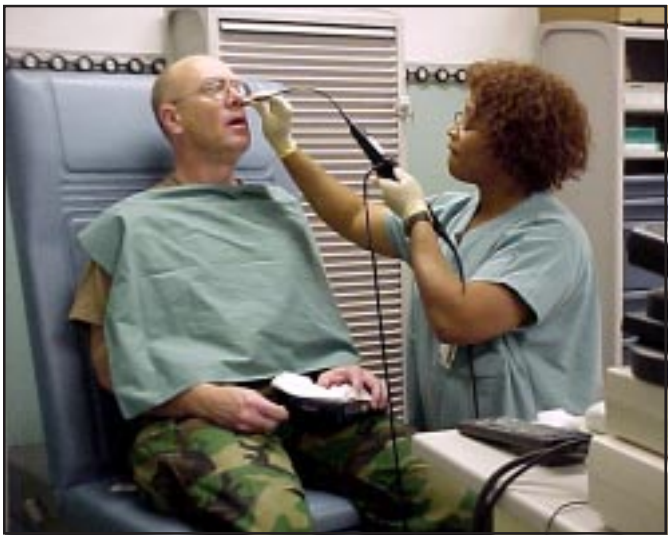
He said the changes incorporated in the 2000 defense budget and the recommendations sent to Congress continue Cohen's policy of total force integration. "We need to identify and eliminate any cultural or structural barriers that stand in the way of the seamless integration of this force," he said.

Cragin said he believes Congress will act positively on the proposals and expects the changes to come about incrementally.

"I'm not sure that everything that we suggest needs to be changed tomorrow will, in fact, be changed tomorrow, but we're going to work with Congress on this," he said. "Members of Congress have indicated a keen interest in health care issues as they relate to members of the Guard and Reserve. We're really looking forward to working with them on these issues."

Telemedicine in TRICARE Region Nine

By Cmdr. Bobbi Crann, NC, USN



During a telemedicine consultation, the patient sits in front of the monitor and camera and is able to talk to and see the specialist. The local healthcare provider acts as the remote specialist's hands and positions the medical scopes for the necessary views.

A 23-year-old SeaBee suffering from chronic sinusitis for the last six months has been referred to an Otolaryngologist at Naval Medical Center San Diego. At the appointment, he discusses his symptoms with the specialist and then an examination takes place. A routine patient-physician encounter — except the patient isn't sitting in the specialist's office. The patient is 175 miles away sitting in an exam room at Branch Medial Clinic, Port Hueneme, participating in a telemedicine appointment.

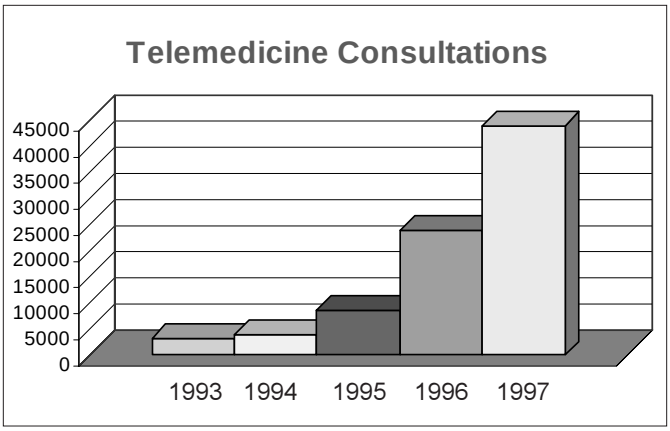
Telemedicine

Telemedicine is defined as the exchange of clinical information from one site to another via electronic communications. Telemedicine can be as simple as telephone triage or as intricate as real time video teleconferencing. Telemedicine is used for both patient examination and education of the patient and/or health care provider, but the primary benefit of telemedicine is better access to specialty care.

Telemedicine has been in use since the 1960's when NASA began to measure physiological parameters from both the spacecraft and space suits during missions. These early efforts and the continued development in technology have fostered the development of telemedicine. Early systems were expensive, but with the growth of technology and decreased costs, there has been resurgence in the utilization of telemedicine. Specialties that commonly use telemedicine include dermatology, oncology, surgery, cardiology, otolaryngology, internal medicine and mental health. Newer disciplines include tele-disease management and tele-case management. One of the largest uses of telemedicine is tele-radiology, which involves the transmission of medical images to a radiologist for interpretation.

How the Telemedicine Program Began

In 1996, a regional survey was done to assess the need for a Telemedicine Program. TRICARE goals include timely access to care, cost-containment and patient satisfaction and the study revealed a noteworthy lag in access to specialty care for the active duty patient. TRICARE Region Nine encompasses Southern California, and contains remote sites, some of which are 300 miles away from the specialty care at Naval Medical Center, San Diego. The survey also noted that the active duty patient lost an average of eight hours of worktime for each provider appointment. With all of this in mind, a business plan was written, and submitted to Health Affairs. In 1997 TRICARE Region Nine was approved and funded $760,000 to initiate a regional interactive (real-time)



Source: Allen A.; Grigsby B. 5th Annual program survey. Telemedicine Today. 6(5):18-19; 1998.

Telemedicine Program.

Equipment

Equipment is a large cost in a telemedicine program. The program's telemedicine equipment includes a rhinolaryngoscope, electronic stethoscope, otoscope, and opthalmoscope and base camera with illumination. This equipment enables the health care provider to do an exam while the specialist watches on a monitor. The video-teleconference is 30 frames per second, which provides a high-quality picture.

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Naval Medical Center Breast Health Center Honored

By JO2 Stacie Rose
Navy Compass Staff Writer

The Breast Health Center at Naval Medical Center has often been recognized for its dedication to its customers, and its constant focus on customer satisfaction.

Recently, the Breast Health Center was presented a national award. The Center received the 1999 Wyeth-Ayerst Gold Hera Award for "noteworthy improvement in women's and children's health outcomes."

It is the first time a military medical facility has received this honor since the inception of the award program in 1996.

In a small ceremony held in the Breast Health clinic, Capt. William Roberts, Deputy Commander of Naval Medical Center San Diego, presented the trophy and plaque to Capt. Melissa Kaime and the staff.

In his remarks, Roberts noted that previous winners of the award are all exceptional facilities, some known world-wide for their medical advancements.

"I am extremely proud to have the Breast Health Center as part of the Naval Medical Center," he said. "It is an honor, and this award belongs to the entire staff of this clinic."

Capt. William Roberts, Deputy Commander of Naval Medical Center San Diego, presents Capt. Melissa Kaime, Department Head of the Breast Health Center, with the 1999 Wyeth-Ayerst Gold Hera award. (Photo by JO3 Stacie Rose)

The Breast Health Center was established in 1997, and incorporates all facets of breast health, including diagnostics, support, and physical therapy.

They also offer a number of programs to patients, such as the annual Breast Cancer Survivors' Day, support groups, and educational courses.

Telemedicine

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The Referral Process

The telemedicine process starts with the Primary Care Manager. He/she routes a consult to the 'telemedicine consult manager' at the Military Treatment Facility and the information is transcribed into an Internet-based scheduler called the ***Referral Management Scheduler (RMS).*** This 128-bit encrypted web-based program allows a patient to be registered and scheduled for a telemedicine appointment and then sends an email to the specialist. For security reasons, patient identifiers are not included in the email. That information can be gathered over the web-based schedule. During the telemedicine consult, the specialist can write his/her note into the web-based consult. The Military Treatment Facility then brings up the web-based consult, prints out the note and places a copy into the patient's record.

The Telemedicine Session

On the day of the telemedicine appointment, the patient is briefed about the program and asked to sign an informed consent. In order to start the consult, the *referring* site dials in over ISDN lines to Naval Medical Center, San Diego and the encounter becomes a video-teleconference with added medical equipment. The specialist begins the consult with patient complaints, and then moves on to examine the patient. Directing the Health Care

*See **Telemedicine**, page 8*

New Patient Advocate System Coming to TRICARE

By Douglas J. Gillert
American Forces Press Service

ALBUQUERQUE, N.M. — Patients in the TRICARE military healthcare system soon will have a new source of help when they face problems with their care.

Beneficiary counseling and assistance coordinators will be added to the staffs of regional TRICARE lead agent offices and military treatment facilities within the next eight months, according to Dave Bartley of the TRICARE Management Activity.

Full-time employees will fill the regional positions, while the clinic and hospital level slots most likely will be filled on a part-time basis, Bartley said at the TRICARE Communications and Customer Service conference here Nov. 3. He said the regional advocates will have toll-free telephone numbers patients can call if they can't resolve their problems at the local level.

In many cases, the positions already exist under different titles, Bartley said. However, the fiscal 2000 Defense Authorization Act established the new position and title for clarity and to give patients a clear path to help when they need it. Bartley said the legislation will standardize the advocates' services nationwide.

Bartley said he envisions the new advocacy office as a "buck stops here" setup. Once patients elevate their concerns to the new office, they should not have to call anyone else to get their questions answered and problems resolved, he said.

Military hospitals already have patient advocates, and Bartley said the new positions won't take power away from them but add to the overall ability of the military health system to respond to patient needs.

Before the advocacy offices begin business, a new DoD instruction will have to be written, Bartley said. A working group will begin working out details in December, he said.

Patients with problems or questions about their health care should continue to first contact their local health benefits advisers at clinics and hospitals, he said. In addition, each regional TRICARE contractor provides TRICARE enrollees with a toll-free telephone help line. The numbers are provided to enrollees and also are posted on the TRICARE Web page <www.tricare.osd.mil>.

Telemedicine

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The remote specialist is able to talk to both the local doctor and patient, and see the same view as if he were actually with the patient.

provider and patient during the exam, the specialist can conduct a thorough assessment. If an evaluation cannot be satisfactorily performed via telemedicine, the specialist may request an in-person evaluation.

Current Programs

In August 1997, the Otolaryngology Department at Naval Medical Center, San Diego began seeing active duty patients via telemedicine. The first site to go "live" was Naval Medical Clinic, Port Hueneme. Technical glitches not withstanding, the sessions went smoothly and patient satisfaction was high.

By March of 1999, six sites were receiving telemedicine services. The bulk of the consults are for otolaryngology, however tele-neurology and tele-psychiatry are offered on a limited basis.

The Tele-Child & Adolescent Psychiatry Program began out of need at Naval Hospital, Twentynine Palms. A pediatrician at the hospital was battling the "medical isolation" of the Mojave Desert. He needed the assistance of a child psychiatrist to help some of his patients overcome behavioral disorders. There were none readily accessible,

*See **Telemedicine**, page 9*

February is National Children's Dental Health Month

By Lt. Bob Tatum, USN

Dental care is an important part of a person's overall health, especially in children. Not only are children's teeth constantly changing, but children are developing oral hygiene habits that will carry them through life. For this reason, February is designated as the National Children's Dental Health Month, and military dental clinics throughout Region Nine are participating.

"Basically the whole emphasis is to push education and prevention," said Navy Lt. Jennifer Statler, a dental officer at Naval Dental Center Southwest in San Diego. "Throughout California, Naval dental clinics are conducting community outreach programs. One of the big things we do is to visit classrooms, pass out toothbrushes, and talk to the kids about proper dental care," Statler said.

The annual observance focuses mainly on educating parents and children about the importance of proper dental care, and how to properly care for a child's teeth. Local observances often include poster, coloring, and essay contests, health fairs, free dental screenings, museum exhibits, classroom presentations and dental office tours.

"These outreach programs are important because families need to get involved with their children's dental healthcare, and this is a good way to get the message out," said Statler, who is the Navy's Children's Dental Health Month coordinator for all of California and Fallon, NV. "The program also gets children involved in their own healthcare and teaches them proper oral hygiene," Statler said.

More information about the National Children's Dental Health Month is available from your dentist, or visit the American Dental Association's Web site at http://www.ada.org/consumer/ncdhm/nc-menu.html.

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even in the somewhat larger community of Palm Springs some 50 miles away. The closest suitable specialist was at nearly 100 miles away – an inconvenience to his patients and families, to say the least. The difference from the other program is the equipment. Using a Videophone connected to a telephone outlet, touch-tone telephone and to a television, this equipment allows for about 15 frames per second as compared to 30 frames per second with the high bandwidth program.

Metrics

Since the first telemedicine consult, measurements of cost-effectiveness have been gathered. In order to collect the data, travel costs and man-hours lost were determined for each Military Treatment Facility. For example, from Edwards Air Force Base to San Diego, it is a round trip of 402 miles and a full day of work is lost.

To date, there have been over 700 telemedicine encounters which amounts to $150,000 in travel costs deferred and 9,000 man-hours saved.

Patient Satisfaction

The question of telemedicine being 'impersonal' is a concern often voiced by health care providers and the thought of not examining a patient 'in person' is a hard concept to envision. Based on our patient satisfaction surveys, the majority of patients were pleased with the telemedicine encounters and felt they received quality health care. Many have expressed their appreciation at not having to drive to San Diego, particularly through Los Angeles traffic.

Challenges

Ironically, the same equipment that enables telemedicine can also hamper the program. Because of the complexity of the equipment and network, technical problems do arise and can cause appointment cancellations. There have been approximately 35 cancellations over the last two years due to equipment malfunction. The majority of those 35 patients were re-scheduled for another telemedicine appointment.

A lack of understanding and staff uncertainty also lends to the challenge of deploying telemedicine. Once providers see a live consult, there is often more interest in using telemedicine. Patients are even asking for follow-up appointments using telemedicine.

Summary

Over the last two years, the TRICARE Region Nine Telemedicine Program has resulted in improved access to specialty care plus enhanced operational readiness for our active duty patients. The focus has been on active duty patients, although we have included dependents when the need was demonstrated. Patient satisfaction with this complementary health care service remains high and word continues to spread of the available telemedicine services.

Computerized Records Makes Patient Transfer Easy

The Transportable Computerized Patient Record (TCPR) functionality has recently been tested successfully between NMC San Diego (MCRD) and NH Camp Pendleton. MCRD personnel have been (and are continuing to) transmit recruit records to the Camp Pendleton CHCS System once they are registered in the San Diego CHCS. This assures that marine recruit records are active even before reaching Camp Pendleton for follow-on training and also relieves the significance workload of completely registering recruit patients in two different CHCS databases.

Specifically, TCPR enables a user to electonically generate a complete patient record (or batch of records) to be exported between DOD Medical Faclities once some limited File and Table build is complete. The transmission can include all Ancillary Orders, Inpatient Episodes, Immunization History, Outpatient Appointment Summary, Allergy Information, Consultation results, and Patient Progress Notes/Problem Lists. Moreover, if the patient has not been previously registered at the gaining MTF, the patient will automatically be registered as a patient - as long as the recruit has been previously entered into the DEERS database.

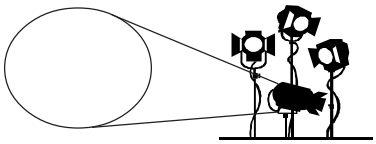
Once received at the gaining MTF, the patient information can be retrieved and reviewed by appropriate personnel, even before the patient arrives, to assure continuing care as required due to change of patient duty location, medical evacuation, emergencies, etc.

To move a patient record, the user simply accesses the order entry menu, selects the appropriate TCPR functionality, the desired patients, and the applicable recipient MTF and then transmits the file. Transmissions occur automatically and once CHCS v4.603 is loaded - fully encrypted. Once transmitted, the record(s) are quickly available to authorized users at the gaining facility. This data flow is contained in the attachment. The records are automatically purged by the system based on local site parameters.

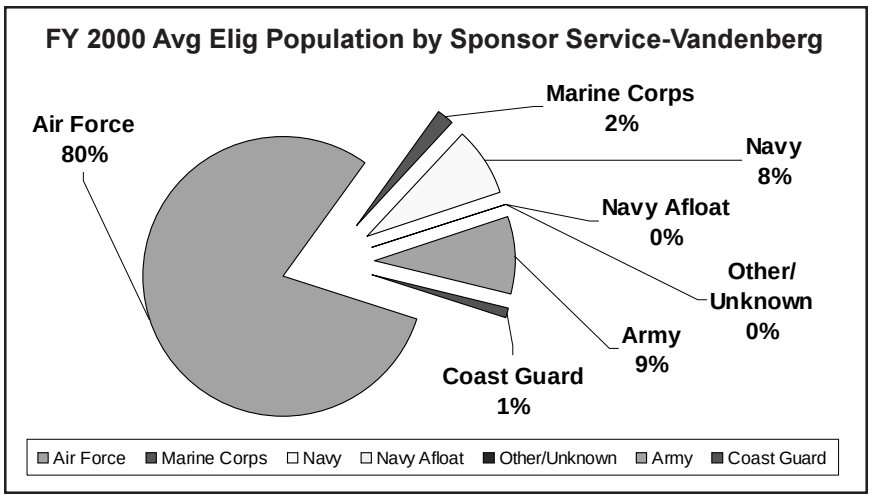
Finally, TCPR could be used to routinely transmit the patient medical information for Naval Personnel and their families from the losing MTF to the gaining duty station. This would assure the arriving personnel are fully registered in the gaining patient database so that the most recent medical history is immediately available to providers for emergencies or continuing treatment.

30th Space Wing Medical Group

...at a glance.



30th Space Wing Mission: Conduct and support space and missile launches, operate the Western Range, respond to world-wide contingencies, and host the Vandenberg Community.



Vandenberg Beneficiary Population

Active Duty:	2,890
AD Family Members:	5,118
Guard/Reserve:	30
G/R Family Members:	67
Retired:	3,889
Retired Family Members:	4,279
Survivor:	1,020
Other:	60
Total Eligible Beneficiaries:	**17,353**

Region Nine Focuses Time and Resources for 2000

By Martha DeMers

How do you decide what's important? And how do you decide what you can stop doing in order to start doing the important stuff? The Office of the Lead Agent, TRICARE Southern California, (OLA) has been spending some time wrestling with these questions during strategic planning sessions. The Executive Team was in complete agreement from the outset that the primary goal of the OLA is to facilitate the success of the MTFs in meeting the TRICARE mission. Thus, the strategic goals are set with the good of the beneficiaries, the military treatment facilities and the military health system in mind.

The Team has been focusing on areas that require special attention in the immediate future. Areas that have been identified include:

- Provider and beneficiary training
- A coordinated population health management program
- Use of business tools and technology to make business decisions (for both the MTFs and the OLA)
- Working with the MTFs to optimize the regional health care system
- Preparation for the 3.0 TRICARE Contract
- Ensuring the full TRICARE Prime Benefit to active duty.
- Regional education and training

So far the team has found nothing that can be stopped, so a major challenge is spreading the existing resources over the ever-expanding pie. That's what strategic planning is all about.

Attention Active Duty Troops in Remote Locations: Enroll Now in TRICARE Prime Remote!

If you are on active duty and you work *and* live in a remote area, you may be eligible to enroll in the TRICARE Prime Remote Program!

The Department of Defense (DoD) is committed to bringing the highest quality health care to active duty service members, even when they are stationed in places where there are no military treatment facilities. On October 1, 1999, the DoD began a new health care program to help active duty members get health care more easily when they are assigned to remote locations. The new program is called TRICARE Prime Remote.

Under TRICARE Prime Remote, active duty service members who work *and* live more than 50 miles (based on zip codes) from a military treatment facility or clinic can receive most of their medical and dental care from local civilian doctors. If you live in a remote area, in most cases, you no longer have to travel long distances to a military treatment facility. With TRICARE Prime Remote, you can see a doctor in your neighborhood.

The DoD identified zip codes that were 50 miles from the nearest military treatment facility. If you are active duty, and work *and* live in these zip codes, you qualify for the program and must enroll.

There are special "dos" and "don'ts." You must be sure to follow the procedures to get care when you need it. To find out if you qualify for TRICARE Prime Remote, to enroll, or for more information, call (800) 242-6788 and press option 1, then 3. Or, you also may visit our Web site at **www.fhfs.com**.

Special rules apply in these states:

In Alaska: All active duty service members in Alaska are part of, and must be enrolled in, the TRICARE Prime Remote program, except for those in the Elmendorf, Bassett or Eielson areas or in an area with a Coast Guard clinic, such as Kodiak, Juneau, Sitka or Ketchikan.

In Hawaii: All active duty service members in Hawaii on islands other than Oahu will be enrolled in TRICARE Prime Remote.

Departmental Focus: Analysis & Evaluations

By Lt. Bob Tatum, USN

The Analysis and Evaluation Department, otherwise known as A&E, exists to meet the data needs of military hospitals and clinics in Region Nine. Using the Composite Health Care System (CHCS) and other data networks, A&E collects, analyzes and displays the data in different ways, depending on the specific needs of the people who are using it. Lt. Col. Dale Villani, USAF, sees an increasing need for quality data collection and analysis.

"The primary use for the data is to ensure we are providing the appropriate level of care to our beneficiaries," said Villani, the department head for A&E. "You can't do managed care without data — data drives managed care. We provide data into the hands of the people who need it. The data is the feedback to the care managers; it is a continuous process," Villani said.

One of the products A&E uses to organize data is the Commander's Data Book. A separate monthly Commander's Data Book is produced for each hospital commander, listing data about that hospital which can help the commander evaluate the hospital's performance. Statistics on beneficiary demographics, number of inpatient and outpatient visits, types of budget expenditures and other data all help the hospital commander to ensure the hospital is running efficiently. A&E also helps commanders to interpret the data without making judgements. While the Commander's Data Book does not show data from other hospitals, much of the local data is compared to regional or national benchmarks.

The A&E department consists of military and civilian employees, as well as contractors. All have expertise in data analysis and statistics, as well as a background in managed care. Department staff are often on the road providing staff assistance visits to discuss data with each hospital commander.

"Data collection methods have become more sophisticated. With downsizing at many military hospitals, there aren't enough people to collect and analyze all the data," said Villani.

Villani sees the future of data collection as a fast-moving train. With new data collection systems emerging all the time, it is a challenge to keep up with what is happening in the data collection field. He sees the future of data collection going paperless, and is always looking to improve our data systems.

"We need to stay on the cutting edge of the new data systems, and put the data in the hands of the people who need it," Villani said.

Front left to right: Mark Eckman, Ginger Schwenkler, Jolene McGarvey, MQ Shelton, Veronica Parker; rear left to right: Joe Marasciullo, LTC Leland Jurgensmeier, Lt Col. Dale Villani.